State of California

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please complete in triplicate (type, if possible) Mail two copies to:

OSHA Case No.

☐ Fatality

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony

NOTICE: California law requires employers to report within **five days** of knowledge every occupational injury or illness which results in lost time beyond the date of the incident **OR** requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within **five days** of knowledge an amended report indicating death. In addition, every serious injury/illness, or death must be reported **immediately** by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. FIRST NAME	1A. POLICY NUMBER	DO NOT USE THIS COLUMN
2. MAILING ADDRESS (Number and Street, City Code)	2A. PHONE NUMBER	Case NO
3. LOCATION, IF DIFFIRENT FROM MAILING (Number and Street, City, Zip)	3A LOCATION CODE	Ownership
4. NATURE OF BUSINESS, e.g., painting contractor, wholesale grocer, sawmill, hotel, etc.	5. STATE UNMPLOYMENT INSURANCE ACCT. NO.	Industry
6. TYPE OF EMPLOYER ☐ ☐STATE CITY COUNTY SCHOOL DISTRICT ☐		Occupation

EMPLOYEE

EMPLOYEE NAME	8. SOCIAL SECURITY NUMBER	9. DATE OF BIRTH (mm/dd/yy)	Sex
10. HOME ADRESS (Number and Street, City, Zip)		10A. Phone Number	AGE
11. SEX ☐MALE ☐FEMALE	12. OCCUPATION (Regular job title) – No initial, abbreviations or numbers	13. DATE OF HIRE (mm/dd/yy)	Daily hours
14. EMPLOYEE USUALLY WORKS ____ hours per day ____ days per week ____ total weekly hours	14A. EMPLOYEMENT STATUS (State applicable status at time of injury) ___Regular Full Time ____ Part Time _____ temporary ____ seasonal	14B. Under what class code of your policy were wages assigned?	Days per week
15. GROSS WAGES/SALARY $ _____ PER _____	16. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g., tips, meals, lodging, overtime, bonuses, etc)? ☐ YES, $_____ Per _____ ☐ NO		Weekly hours

INJURY OR ILLNESS

17. DATE OF INJURY OR ONSET OF ILLNESS (mm/dd/yy)	18. TIME INURY/ILLNESS OCCURRED _____A.M. _____P.M.	19. TIME EMPLOYEE BEGAN WORK _____A.M. _____P.M.	20. IF EMPLOYEE DIED, DATE OF DEATH (MM/DD/YY)	Weekly Wage
21. unable to work for at least one full day after date of injury ☐ yes ☐no	22. DATE LAST WORKED (mm/dd/yy)	23. DATE RETURNED TO WORK (mm/dd/yy)	24. IF STILL OFF WORK CHECK THIS BOX. ☐	County
25. PAID FULL WAGES FOR DAY OF INJURY OR LAST DAY WORKED? ☐YES ☐NO	26. SALARY BEING CONTINUED ☐YES ☐NO	27. DATE OF EMPLOYER'S KNOWLEDGE/NOTICE OF INJURY/ILLNESS (MM/DD/YY)	28. DATE EMPLOYEE WAS PROVIDED EMPLOYEE CLAIM FORM (MM/DD/YY)	Nature of injury
29. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS, if available e.g., second degree burns on right arm, tendentious of left elbow, lead poisoning.				Part of Body
30. LOCATION WHERE EVENT OR EXOSURE OCCURRED (Number, Street, City)	30A. County	30B. ON EMPLOYER'S PREMISES? ☐YES ☐NO		Source
31. DEPARTMENT WHERE EVENT OR EXPLOSURE OCCURRED, e.g., Shipping department, machine shop.		32. OTHER WORKERS INJURED/ILL IN THIS EVENT? ☐YES ☐NO		Event
33. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN THE EVENT OR EXPOSURE OCCURRED, e.g., acetylene, welding torch, farm tractor, scaffold.				Sec. Source
33. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OF EXPOSURE OCCURRED e.g., welding seams of metal forms, loading boxes onto truck.				Extent of injury
35. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g., worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand, USE SEPARATE SHEET IF NECESSARY.				

36. NAME AND ADRESS OF PHYSICIAN (Number and Street, City, Zip	36A. PHONE NUMBER
37. IF HOSPITALIZED AS AN INPATIENT, NAME AND ADDRESS OF HOSPITAL (Number and Street, City, zip)	37A. PHONE NUMBER

Completed by (Type or Print)	Signature	Title	Date

FORM 5020 (REV. 6) **FILING OF THIS REPORT IS NOT ADMISSION OF LIABILITY**